FINANCIAL INCENTIVES FOR PROVIDERS IN MANAGED CARE PLANS FINDINGS AND RECOMMENDATIONS

I. FINDINGS

Physicians and other appropriately-licensed health professionals operating within the scope of their practice (i.e., health practitioners or providers) are motivated by many incentives. Compensation arrangements are one important factor that may impact the quality and cost of care. Other, arguably more, important factors at work include professional ethics and providers' desire for the esteem of their peers. These incentives drive practitioners to give good care and work hard regardless of how they are paid.

All compensation arrangements contain incentives, which may have positive and negative effects. Under fee-for-service (where payment occurs only if service is rendered), health practitioners have incentives to provide at least the care, and sometimes more care than, patients need. Payment on a capitation basis (where prepayment for the potential use of services occurs regardless of whether or not care is rendered) may create incentives to provide appropriate care, or to provide less care than needed. Compensation through salary provides an incentive to provide appropriate care, but may impede productivity. Many providers participate in bonus and withhold incentive arrangements which may be designed to encourage quality and consumer responsiveness, or may be weighted excessively toward financial considerations.

There is almost an infinite array of compensation arrangements. These arrangements are often very complex and therefore, in most instances, may not be amenable to regulation. Nor is there direct conclusive evidence of the relationship between specific financial arrangements and adverse outcomes. However, some arrangements are not in the public interest and should be restricted because they create too great an incentive to deny necessary medical care. In general, the greater the intensity of incentives, the more likely they are to affect specific clinical decisions. Of particular concern are incentives that place individual or small groups of health practitioners at risk for the cost of referrals for their patients. Stop-loss insurance, reinsurance, and especially risk adjusted payments to providers can alleviate some of the potential problems associated with capitation.

According to one national survey of physicians and managed care plans, approximately half of all American physicians have at least some patients whose insurance plans place the physician at some financial risk. Health plans reported an average of 12% as the maximum percentage by which an individual primary care physician's annual income may vary each year as a result of financial incentives.[1]

Both federal law[2] (applicable to Medicare and Medicaid patients) and state law[3] prohibit arrangements that are an inducement to limit or reduce necessary services to an individual enrollee. Federal law also requires that physicians who are placed at substantial financial risk have specified stop-loss protection.

Though the information is complex, patients and enrollees may benefit from disclosure of financial incentives by health plans and medical groups. State law requires health plan disclosure of incentives. Federal law (for Medicare and Medicaid patients) requires disclosure of incentive arrangements where

[1] Gold M, Hurley R, Lake T, et al., "Arrangements between managed care plans and physicians. Selected external research series no. 3.", Washington, DC: Physician Payment Review Commission, 1995.
[2] Sections 4204(a) and 4731, OBRA 1990, Public Law 101-508; and HCFA Regulations 42CFR, Section 417.479.
[3] AB 2649, 1996, is now part of the Health and Safety Code, Section 1367.10.

physicians are placed at substantial financial risk. Disclosure by individual practitioners may also benefit patients provided it is done in a manner that is sensitive to the provider-patient relationship. Practical implementation of further disclosure requirements may be difficult, though worth exploring.

Health plans, purchasers, government entities, and accreditation agencies have not sufficiently researched and identified provider compensation arrangements that produce the most appropriate care and best outcomes.

II. RECOMMENDATIONS

1. Health plans should be required to disclose to the public specific information about the scope and general methods of payment made to their contracting providers of health care services and the types of financial incentives used to enable consumers to evaluate and to compare plans. Disclosure should use clear and simple language, including a suggestion that if an individual wishes to know more about their providers' or provider groups' method of reimbursement, they can ask their medical group/IPA, provider, or health plan.

2. The state entity for regulation of managed care[4] should conduct a pilot project with a variety of health plans, their contracting medical groups, other provider groups, and consumer groups to develop clear, simple, and appropriate disclosure language (field-tested for consumer understanding and value) and the most cost-effective methods for distribution to enrollees. The state entity for regulation of managed care should report results back to the Legislature to consider how best to approach provider group disclosure.

3. Provider groups and health practitioners should be required to disclose the scope and method of compensation and financial incentives they receive, upon the request of a patient. Provider groups should also be required to disclose the methods of compensation and incentives paid to their subcontracting providers.

4. (a) Health plans and provider groups should be prohibited from adopting an incentive arrangement in which an individual health practitioner receives a capitation payment for a substantial portion of the cost of referrals[5] for that practitioner's patients. (Aggregated or pooled risk arrangements of, for example, five or more practitioners should be excluded from the prohibition in 4(a) and the requirements in 4(b).)

   (b) The state entity for regulation of managed care should be required to review and approve the following types of incentive arrangements:
   - where an individual health practitioner receives an incentive tied to a substantial portion of the cost of referrals of that practitioner's patients or
   - where a very small group (e.g., fewer than five) receives such an incentive or a capitation payment for a substantial portion of the cost of referrals for the group's patients.

   These arrangements should not be approved in the absence of a determination that there is a patient panel of sufficient size to spread risk, sufficient time over which the capitation or incentive applies, and adequate provisions to assure quality care and to protect against high risk cases through stop-loss or risk adjustment.

[4] Throughout this paper, the "state entity for regulation of managed care" means the Department of Corporations or its successor agency.

[5] For purposes of this discussion, referrals do not include services performed in a provider's office.

(c) The state entity for regulation of managed care should ensure that health practitioners who contract with health plans, who treat commercial patients, and who are at substantial financial risk (as currently defined by federal law) obtain stop-loss coverage, maintain sufficient reserves, or have other verifiable mechanisms for protecting against losses due to adverse risk. This provision should be administered in a manner that minimizes the administrative burden on practitioners and plans to the extent possible.

5. Sponsored purchasing groups, such as the Pacific Business Group on Health, and accreditation organizations, such as the National Committee for Quality Assurance, should review provider incentive compensation arrangements (including non-financial incentives) for the purpose of identifying best practices and practices in need of improvement, and seek to influence plan and provider groups accordingly. Particular attention should be paid to the promotion of risk factor measurement (e.g., morbidity and mortality rates) and risk adjustment and compensation arrangements that continue to include rewards for quality care, consumer satisfaction, and other non-financial factors.

6. An advisory group should be convened by the state entity for regulation of managed care, including major stakeholders[6] to review provider compensation arrangements, identify best practices, and practices in need of improvement, and advise the state entity for regulation of managed care regarding the need for changes in regulatory oversight.

7. The state entity for regulation of managed care should develop internal expertise in assessing compensation arrangements.

[6] The intention of the task force is that stakeholders include, but are not limited to, consumer groups, including representatives of vulnerable populations, providers, provider groups, health plans, and purchasers.